

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00440

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Victoria		Fist	Middle	Last	4. DATE OF DEATH Coates I-29	Month	Day	Year 1958
S. SEX F.	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 11 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Benjameia Kyler		14. MOTHER'S MAIDEN NAME Rosetta Kyler						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 4500		16. SOCIAL SECURITY NO.		17. INFORMANT Huntingtown Md. Granddaughter Dorothy Wallace				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO Heart failure - Demyelinating artero-sclerosis Arter. aneur.		INTERVAL BETWEEN ONSET AND DEATH				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Owings		(County) (State)
21. I certify that I attended the deceased from _____ to _____ that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Roberto De Villanueva						ADDRESS (Street, city or town, state) 54 Reservoir		DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify) Feb. 1, 1958		22b. DATE THEREOF Feb. 1, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Little Reformation Church		22d. LOCATION (City, town, or county) Owings, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Leroy E. Berry		ADDRESS Huntingtown, Md.		24a. REC'D BY REGISTRAR DATE FEB 3 '58		24b. REGISTRAR'S SIGNATURE Albert Beach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

DEPARTMENT OF STATE
DEPARTMENT OF HOMELAND SECURITY

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
FEB 3 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00441

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		441 Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		Maryland b. COUNTY			
Prince Frederick		9 Days		Lusby c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Calvert Co., Hospital							
3. NAME OF DECEASED (Type or print)	First Merle	Middle	Last Cox	4. DATE OF DEATH	Month Jan.	Day 7	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1883	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Builder		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George M. Cox				14. MOTHER'S MAIDEN NAME Lydia B. Hammersley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Retired</i>				16. SOCIAL SECURITY NO. 17. INFORMANT 216-16-405X Son - Mike Cox Lusby Md.			
Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteria</i> -							
450.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Generalized arterio-sclerosis</i>							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
						20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec. 1957</i> , to <i>Jan 7, 1958</i> , that I last saw the deceased alive on <i>Jan 7, 1958</i> , and that death occurred at <i>3rd</i> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>5th Ward, Baltimore, Md.</i>							
DATE SIGNED <i>1/7/58</i>							
ACTUAL SIGNATURE <i>Roberto De Villarreal</i>							
PHYSICIAN'S NAME (Type) Dr. Roberto De Villarreal							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 10, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Middleham Chapel</i>		22d. LOCATION (City, town, or county) <i>Lusby - Calvert Co - Md</i>	
(State)							
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. J. Harkness & Son - Mutual, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JAN 10 '58</i>		24b. REGISTRAR'S SIGNATURE <i>De Villarreal</i>	

DEPARTMENT OF JUSTICE - BUREAU OF INVESTIGATION
CERTIFICATE OF DEATH

BUREAU U. S.

JAN 10 19

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00442

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	Calvert		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
		MARYLAND	a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Lusby</i>		<i>Lusby</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First <i>Mayo</i>	Middle <i>Curr</i>	Last <i>Dawkins</i>	4. DATE OF DEATH	Month <i>11</i>	Day <i>19</i>	Year <i>58</i>
5. SEX <i>F</i>	6. COLOR OF EYES	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	WIDOWED <input checked="" type="checkbox"/> DIVORCED <i>Aug 16 Approx.</i>	9. AGE (In years less birthday) <i>70 1/2</i>	10. IF UNDER 1 YEAR Months <i>1</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Boatman</i>				<i>Md</i>			
13. FATHER'S NAME <i>Andrew Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Curr Johnson</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <i>May Dawkins, Lusby Md</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442x</i>	
DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)
DUE TO	
	(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>Was feeling badly at 5 AM and died at 10 PM</i>		

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. <input type="checkbox"/> p. m. <input checked="" type="checkbox"/>	Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Lusby</i>	(County) <i>Calvert</i>	(State) <i>Md</i>

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
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ACTUAL SIGNATURE <i>H W Ward</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>1/19/58</i>
EXAMINER'S NAME (Type)	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>1-23-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St Johns</i>	22d. LOCATION (City, town, or county) <i>Lusby</i>	(State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sawell Prince Frederick</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>JAN 22 '58</i>	24b. REGISTRAR'S SIGNATURE <i>John E. Sawell</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the registrar prior to burial or cremation.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial or removal.

ST. LOUIS STATE POLICE DEPARTMENT OF AIRPORT - SECURITY
RECEIVED BY WING, CHIEF OF GUARD

BUREAU V. S.

NOV 20 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00443

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be referred to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <i>maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
d. STREET ADDRESS <i>Huntingtown, Md.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Benjamin J.</i>	Middle <i>Hawkins</i>	Last 4. DATE OF DEATH Month Day Year 1 15 1958
5. SEX <i>m</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 22</i>
9. AGE (In years last birthday) <i>5 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Painting</i>	11. BIRTHPLACE (State or foreign country) <i>maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	Address <i>Benj. Hawkins Sr. Huntingtown Md</i>		
13. FATHER'S NAME <i>Benj. Hawkins</i>	14. MOTHER'S MAIDEN NAME <i>Waisy Mackall</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>929.8</i>	16. SOCIAL SECURITY NO. <i>929.8</i>	17. INFORMANT <i>Benj. Hawkins Sr. Huntingtown Md</i>	INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>929.8</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE CRIMINAL/DISEASE CONDITION GIVEN IN PART I(a) <i>Child was playing and fell in pond</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>While at work</i>	
20c. TIME OF INJURY Hour <i>3 p.m.</i>	Month, Day, Year <i>1/15 1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Garden</i>
20f. (City or town) <i>Calvert</i>	(County) <i>Md</i>	(State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.W. Ward</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. (BURIAL) CREMATION, REMOVAL (Specify) <i>1-18-58</i>	22b. DATE THEREOF <i>1-18-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Edwards</i>	22d. LOCATION (City, town, or county) (State) <i>Sunderland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Sewell Prince Frederick Md</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE JAN 22 '58	24b. REGISTRAR'S SIGNATURE <i>Reverend</i>

BUREAU V. S

JAN 20 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00444

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

447 Items 11,12 Film 224 1-13-58 et

Reg. Dist. No.

1 **10** DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
2 **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <i>Md</i>	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <i>Stone Harbor</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <i>H. Beach Md</i>	
d. NAME OF HOSPITAL OR INSTITUTION [If not in hospital, give street address] <i>Calvert Nursing Home</i>		d. STREET ADDRESS <i>11 Beach Rd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Wade Bradley</i>		4. DATE OF DEATH Year Month Day Year <i>1958</i>	
5. SEX <i>M</i>		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/30/78</i>	
9. AGE (in years mo. day) yrs.		10. LOCAL OCCUPATION [Give kind of work done during most of working life, even if retired] <i>Floyd</i>	
11. BIRTHPLACE (State or foreign country) <i>Frederick, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Miller</i>		14. MOTHER'S MAIDEN NAME <i>May Weisman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>W 1 S 649 11-00000</i>	
17. REFORMANT <i>None</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Calvert vascular renal disease / Mr</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>442x</i>		(b) <i></i>	
DUE TO (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <i>No</i>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Had been to tall fence back yard on rd and died</i>			
20c. TIME OF INJURY Month, Day, Year Hour p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Wash DC</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> <i>Actual Signature</i>			
EXAMINER'S NAME (Type) <i>Wade</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <i>John J. O'Conor</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>1-5-58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Lee's</i>		22d. LOCATION (City, town, or county) (State) <i>Wash DC</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home - Wash DC</i>		24a. REC'D BY REGISTRAR DATE JAN 8 '58	
ADDRESS <i></i>		24b. REGISTRAR'S SIGNATURE <i>R. L. Smith</i>	

WISCONSIN STATE GOVERNMENT OF HUMAN RELATIONS
WISCONSIN EDUCATIONAL & CULTURAL CENTER

BUREAU V.

TAN S 1369

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

448

CERTIFICATE OF DEATH

00445

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cabret</i>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prune Frederick</i>		c. LENGTH OF STAY IN 1b <i>6 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cabret Co. Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X St. Leonard's</i>	
3. NAME OF DECEASED (Type or print) <i>Lucy</i>		d. STREET ADDRESS <i>—</i>	
4. DATE OF DEATH <i>Jan. 7, 1958</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 21, 1867</i>
9. AGE (In years, less birthday) <i>90 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
10c. BIRTHPLACE (State or foreign country) <i>St. Mary's Co., Md.</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Spaulding</i>		14. MOTHER'S MAIDEN NAME <i>Jane Mattingly</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT <i>Harry Jones - Lushy, Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition</i> DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the under- lying cause lost. <i>—</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>—</i>	
19. DUE TO <i>Glaucoma & arterio-sclerosis</i>		(b) DUE TO <i>—</i>	
(c) DUE TO <i>—</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>58</i> , to <i>Jan 7, 1958</i> that I last saw the deceased alive on <i>Jan 7, 1958</i> , and that death occurred at <i>—</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edw. Ellament</i> M.D.		ADDRESS (Street, city or town, state) <i>5th Avenue</i> DATE SIGNED <i>1/8/58</i>	
PHYSICIAN'S NAME (Type) <i>R. E. VILLARREAL</i>		22d. LOCATION (City, town, or county) (State) <i>Solomons - Cabret - Md</i>	
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Jan. 11, 1958</i>		22f. NAME OF CEMETERY OR CREMATORY <i>Our Lady Star of the Sea</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. A. Harkness & Son - Maitland, Md</i>		24a. REC'D BY REGISTRAR DATE JAN 10 1958	
		24b. REGISTRAR'S SIGNATURE <i>G. A. Harkness</i>	

S. A. M.

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00446

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHA3. Page 5 may be retained for records or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial, cremation,

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mutual</i>		c. LENGTH OF STAY IN lb <i>life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Glenn</i>		First <i>W</i>	Middle <i>Ross</i>
4. DATE OF DEATH Month <i>1</i>		Last <i>1</i>	Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR FACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 11, 1898</i>
9. AGE (In years to nearest day) <i>39 yrs</i>		10. IF UNDER 1 YEAR Months <i>8</i>	11. IF UNDER 24 HRS. Days <i>20</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk of Court Justice office</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>WS</i>	
13. FATHER'S NAME <i>James T Ross</i>		14. MOTHER'S MAIDEN NAME <i>Mary Blunt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>John W Ward</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>44</i> DUE TO Conditions, if any, which gave rise to immediate cause (a) (b) (c) DUE TO Conditions, if any, which gave rise to underlying cause (c) (d) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Found dead by bed about 8 AM</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <i>Cardio-vascular cerebral disease</i>	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. W. Ward</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>Darby red</i>		DATE SIGNED <i>1/3/58</i>
EXAMINER'S NAME (Type) <i>H. W. WARD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Jan. 4, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Walters Memorial Cem.</i>	22d. LOCATION (City, town, or county) <i>Island Creek, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. D. Barkness & Son - Mutual, Md</i>		ADDRESS <i>100 Main Street, Mutual, Md</i>	24a. REC'D BY REGISTRAR <i>DA</i>
			24b. REGISTRAR'S SIGNATURE

RECEIVED
17 1953
BUREAU K.G.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

450

CERTIFICATE OF DEATH

Reg. Dist. No.

00447

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b II Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dunkirk		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First George	Middle 	Last Sherbert	4. DATE OF DEATH	Month Jan.	Day 14	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 12 1884	21 73	9. AGE (In years to birthday) 73 yr.	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) screw man				10b. KIND OF BUSINESS OR INDUSTRY State Job Hardware		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Stocket Sherbert				14. MOTHER'S MAIDEN NAME Ida Wilkerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-24-3880		17. INFORMANT Son-Thomas Sherbert		Address Dunkirk Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach INTERVAL BETWEEN ONSET AND DEATH 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- } (b) lying cause last. } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 mar , 19 57 , to 13 Jan , 19 58 , that I last saw the deceased alive on 13 Jan , 19 57 , and that death occurred at 4 3/4 M. , from the causes and on the date stated above. ACTUAL SIGNATURE G Weems ADDRESS (Street, city or town, state) Huntingdon Rd. DATE SIGNED 1-14-58							
PHYSICIAN'S NAME (Type) Dr. George Weems							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-17-58		22c. NAME OF CEMETERY OR CRYSTATORY Smithville		22d. LOCATION (City, town, or county) Dunkirk Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. J. Hutchins		ADDRESS Curry's Rd.		24a. REC'D BY REGISTRAR DATE Jan 14 1958		24b. REGISTRAR'S SIGNATURE G. L. Smith	

3 A RIVER

SECTION

THE RIVER

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
45 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00448

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>	d. STREET ADDRESS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ella</i>	First <i>S</i>	Middle <i>Johnson</i>	Last <i>Young</i>
4. DATE OF DEATH <i>1/8/58</i>	Month <i>Jan</i>	Day <i>8</i>	Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/18/1833</i>
9. AGE (In years and months) <i>19 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>-</i>	12. BIRTHPLACE (State or foreign country) <i>Md</i>
13. CITIZEN OF WHAT COUNTRY?	14. MOTHER'S MAIDEN NAME <i>Louise Kelso</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>	16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT <i>Carrie Vanilla Divine</i>	Address <i>Nancy Young, Edgewater</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>42-1-1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASES CONDITION GIVEN IN PART I (a) <i>Found dead about 12 N in bed</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>-</i>		
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	Month, Day, Year <i>-</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>
20f. (City or town) <i>-</i>	(County) <i>-</i>	(State) <i>-</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.W. Ward</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <i>-</i>	DATE SIGNED <i>1/8/58</i>		
22a. BURIAL/CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-11-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Carrolls</i>	22d. LOCATION (City, town, or county) <i>Barstow</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. J. Sewell - Prince Frederick</i>	ADDRESS <i>-</i>	24a. REC'D BY REGISTRAR DATE <i>1/11/58</i>	24b. REGISTRAR'S SIGNATURE <i>-</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the remains or prior to burial, cremation, or removal.

BUREAU V. 2

JAN 19 1968

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00449

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PN3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

452

1. PLACE OF DEATH a. COUNTY		Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Md b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1st + Chesapeake				xth Beach, Md		1st + Chesapeake	
3. NAME OF DECEASED (Type or print)		First Lewis	Middle J. Smith	4. DATE OF DEATH	Jan 4	Month Year	Day 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
				23 Nov 1880	77 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None		Self-employed		Del.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Unknown		Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		184-07-3783		Daughter		W Beach, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) atherosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							
INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not working <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>G. J. Weems</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>4 Jan 1958</i>					
EXAMINER'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
Burial		1-8-58		Wash Nat Cemetery, Belair Rd, Md			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<i>W. W. Chambers Co 517 11th St E</i>							
				DATE JAN 8 '58			

BUREAU V. S

JAN 8 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00450

453

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 16 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Republic		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) Calvert Co., Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Jerry		First	Middle	Last	4. DATE OF DEATH Watkins	Month Jan.	Day 2	Year 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6	Days 5	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-14-20761		17. INFORMANT Sister in Law		Address Nettie Commodore Port Republic Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1		Arteriovenous occlusion		INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b)		Hypertension c.v.d						
DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				DUE TO (c)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from _____, 19____, to Jan 2, 1958, that I last saw the deceased alive on Jan 1, 1958, and that death occurred at 1 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Roberto De Villarreal</i>		ADDRESS (Street, city or town, state) St. Leonard / 1/3/58						
PHYSICIAN'S NAME (Type) Dr. Roberto De Villarreal		DATE SIGNED						
22a. BURIAL) CREMATION, REMOVAL (Specify) 1 - 4 - 58	22b. DATE THEREOF 1 - 4 - 58	22c. NAME OF CEMETERY OR CREMATORIAL Browns	22d. LOCATION (City, town, or county) Port Republic, Md	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Sewell Prince Frederick Md		ADDRESS Princ	24a. REC'D BY REGISTRAR DATE Jan 7 '58	24b. REGISTRAR'S SIGNATURE Debra J. Smith				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

GENERAL STATEMENT OF HIGHWAY ACCIDENTS

CERTIFICATE OF ACCIDENT

BUREAU V. S.

JAN 7 1958

RECEIVED